Executive Summary
New Jersey Department of Health and Senior Services
Cooperative Agreement (CA) Application
Health Resources and Services Administration (HRSA)
Bioterrorism (BT) Hospital Preparedness Program

***Introduction*:** The purpose of this application is to describe initial steps to upgrade the preparedness of New Jersey's hospitals and health care delivery system to respond to bioterrorism events, non-terrorist epidemics and general disasters.

***Needs Assessment*:** The public health care system in New Jersey was heavily engaged in the response and consequence management efforts of both the WTC attack and the anthrax outbreak in the Fall 2001. These two events put New Jersey's public health care system to the test and allowed state officials to evaluate response efforts. A comprehensive, written debriefing following the terrorist attacks has provided vital information regarding New Jersey's capacity and effectiveness in responding to large-scale emergencies and biological attacks. Through the debriefing, New Jersey health officials determined that there are gaps in internal and external processes that impact New Jersey's ability to respond to a bioterrorism event.

The New Jersey Department of Health & Senior Services (NJDHSS) conducted a comprehensive needs assessment in order to obtain the feedback of critical public health care segments regarding the preparedness of our state's hospitals and health care facilities to respond to and manage a biological attack. A two-fold approach to needs assessment was undertaken in February and March 2002. The first phase of the needs assessment consisted of an open-ended survey that was sent to key public health care agencies/organizations. The purpose of this survey was to identify the most critical needs among New Jersey's hospitals from the perspective of agencies that would interface with the hospitals in the event of a biological emergency. Agencies were asked to identify the top priorities and offer potential solutions to these issues.

Surveys were sent to a variety of organizations representing the constituencies within the public health care system identified as being key stakeholders in the hospital bioterrorism preparedness efforts including physicians, local health departments, EMS providers, nurses, ambulatory care centers, and the State's poison control agency.

In addition to the survey distributed by the NJDHSS, three organizations conducted independent needs assessments that provided insight on potential gaps in New Jersey health care facilities' preparedness. Results from these three independent studies, one conducted by the New Jersey Hospital Association (NJHA), the second by the NJDHSS on behalf of the US Department of Justice (DOJ), and a third by the New Jersey Primary Care Association (NJPCA) were shared with the NJDHSS to help guide the development of an implementation plan.

After the completion of the survey portion of the needs assessment, a Hospital Bioterrorism Preparedness Planning Committee was convened by NJDHSS in an effort to discuss the issues raised in the surveys and to generate workable solutions to these issues.

As a result of the needs assessment, the following issues were identified as the top priority areas for health care facilities bioterrorism preparedness. The percentages indicate how the individuals responding to the survey prioritized health care facilities' most important needs: Education and Training (22%), Communications (18%), Patient Care (15%),Personal Protective Equipment(13%), Decontamination(12%), Pharmaceutical Inventory (5%), Surge Capacity (5%), Security (5%),Transportation(5%).

It is important to note that the surveys conducted by the NJDHSS, NJHA, NJPCA, and DOJ all revealed similar results and validate the selection of issues to be addressed in New Jersey's implementation plans. The above-mentioned items were the most frequently listed gaps identified in the needs assessment process. It is important also to note that all of these activities must be addressed within a coordinated and integrated plan that addresses regionalization of efforts for maximized preparedness and response efforts.

***Hospital Planning*:** Over the last several months, the NJHA has worked with hospitals throughout the state to determine needs related to disaster preparedness. Hospitals, to a varying degree, have begun the process of exploring acquisition of these supplies, equipment and services. In fact, some hospitals have already acquired many of these elements. Hospitals have also begun adjusting their disaster response plans in conjunction with local health department officials, local law enforcement agencies and their county Office of Emergency Management (OEM). Through testing and running drills, hospitals hope to cohesively interact and communicate with all the appropriate stakeholders in the event of an attack or disaster.

It is clear that in the event of any attack or disaster, all hospitals in New Jersey will be a primary point of access for victims. Hospitals' preparedness plans are being developed based on an objective data-driven assessment of needs, focusing on hospitals top identified need areas. Each individual hospital, or group of regional hospitals, will develop a plan that meets the specific characteristics of its physical plants, capacity, staffing resources, geographic location and unique community's needs and assets. Each hospital's plan for large-scale epidemics requires an integrated effort, cooperation among competitors and other healthcare facilities and prior agreements on transfer arrangements and facility reimbursements. Each plan will provide direction to address the following issues:

a. Providing isolation and quarantine for casualties, in close collaboration and coordination with the public health care system, and following guidelines similar to CDC's Type C (contagious) facilities.
b. Addressing overcrowding and the need for hospital diversion, with large numbers of acute casualties arriving on their own or by ambulance, including development of a rapid communication plan with EMS units that allows them to determine a destination immediately, at any time.

c. Preparing a plan on how hospitals will receive patients on a daily basis when several hospitals are on diversion simultaneously.
d. Preparing a plan/mechanism for ensuring safe and prompt movement of equipment maintained by hospitals and EMS systems to the scene of a bioterrorism event.
e. Addressing the special needs of children, pregnant women, the immunocompromised, the elderly and those with disabilities as a soon as possible to ensure access to medically appropriate care.
f. Delivering essential goods and services such as food, water, electricity and shelter to patients and hospitals/healthcare facilities.
g. Providing hospital security to ensure crowd control, patient traffic flow to support triage decisions, and prevention of further terrorist attacks at the hospital.

Regionalization: The state OEM the NJ State First Aid Council (NJSAC) have organized in the state for provision of services into three regions: Northern, Central and Southern. Each region has seven counties, with total populations of approximately 3.49 million, 3.17 million, and 1.75 million in the Northern, Central and Southern regions respectively. Each county has its own OEM, responsible for organizing emergency services within its borders. The state has 114 local health departments (LHDs) that provide services to 566 municipalities, each with its own local board of health.

In 1997, the NJDHSS developed the Local Information Network and Communication System (LINCS) as a concept for specialized regional public health services. At that time, existing LHDs in each county and three major cities were recruited as agencies in which expertise for the identification and containment of diseases and hazardous conditions that threaten the public's health would be built. Currently, 22 strategically positioned LINCS agencies serve as the state's regional public health partners in coordinated disease surveillance, communications, data/information exchange, and response in cooperation with other LHDs, hospitals, physicians, emergency responders, and a variety of community organizations. LINCS was used extensively during the recent terrorist attacks on the WTC and anthrax outbreak to support and coordinate local response efforts.

In view of the coordinating role served by LINCS agencies today, LINCS agencies will serve as the focal point for coordinating bioterrorism healthcare facilities preparedness and response in five regions: North-West, North-East, Central-West, and Central-East and South Jersey. The populations and number of hospitals for each region is as follows:

REGION	POPULATION	NO. HOSPITALS
North-West	1,206,000	15
North-East	2,287,000	24
Central-West	770,000	7
Central-East	2,399,000	21
South	1,753,000	21

LINCS agencies, in conjunction with the NJHA, will be charged with the responsibilities of coordinating regional healthcare facilities preparedness and response planning groups to address the possibility of a potential epidemic or disaster involving at least 500 patients in their region. Regional teams will convene in September 2002 to begin to develop regional plans, with finalization of the plans by the end of the fourth quarter of the initial funding year.

Funds from the HRSA CA will be provided to the NJHA to coordinate regional planning activities, in conjunction with the NJDHSS, LINCS agencies, and all stakeholders. During the 3rd and 4th quarter of the grant period, regional planning meetings will be held, in conjunction with all stakeholders, to determine how best to distribute the funds in each region, based on identified needs. The NJDHSS will distribute funds to acute care facilities based on regional plans and the needs assessments. The distribution of funds will be coordinated with funds that have been made available to hospitals through the US Public Health Services' Metropolitan Medical Response System contracts with Newark and Jersey City. In addition, the NJDHSS will provide funds to organizations that represent facilities that provide direct health care services (e.g. Federally Qualified Health Centers, long term care facilities). The NJDHSS will distribute a minimum of $2,775,000 to these agencies through Health Service Grants.

***Priority Planning Areas*:** All planning will occur in conjunction with plans as outlined in the application to the Centers for Disease Control and Prevention for supplemental funds under the Public Health Preparedness and Response for Bioterrorism Cooperative Agreement (CDC CA):

1. Medications and Vaccines: The NJDHSS, in conjunction with the New Jersey State Police OEM, has begun the process for the development of a statewide plan to receive and distribute medications and supplies as part of managing the National Pharmaceutical Stockpile (NPS), should it be deployed.
2. Personal Protection, Quarantine and Decontamination: As part of the regional planning effort, every acute care hospital will be required to review, develop, or modify their plans for decontamination of patients (preferably outside of the emergency department), quarantining patients, and transporting already uninfected, hospitalized patients to "clean facilities."
3. Communications: Measures to improve communications in the state during a bioterroism/emergency event include the purchase of 800 MHZ radios for all acute care hospitals and other organizations, development of a software application to monitor hospital divert/bypass status, development of a Communicable Disease Reporting System, implementation of a toll-free number for reporting of potential terrorist events, and others.
4. Biological Disaster Drills: Tabletop exercises will be primarily designed to educate participants about problems associated with bioterrorism and to engage them in an interactive workshops that produce meaningful planning outcomes as well as assessment of area readiness for bioterrorism. The participants will include members from federal, state and local governments, law enforcement agencies, EMS, NJSFAC, health care and public health agencies, public information officers, industry and local communities.

5. Education and Training: As described in Focus Area G, CDC CA, the NJDHSS has developed an action plan/timeline for improving the training and education of the public health care workforce, including hospital and EMS workforces. This plan is based on an assessment of existing state and national resources, initiatives and existing capacity and a needs assessment within the state.

Infrastructure/Critical Benchmarks: The NJDHSS has created a Bioterrorism Unit within the Communicable Disease Service, which will be directed by a Bioterrorism Medical Director, who will report directly to Dr. Eddy Bresnitz, the State Epidemiologist (the project director for this application). Dr. Bresnitz will serve as the interim medical director until an individual has been hired by the NJDHSS to fill this position. The Bioterrorism Unit will be divided into three functional sections: Surveillance, Health Education and Clinical. An individual reporting directly to the Bioterrorism Medical Director who will coordinate their activities will manage each section. Ms. Carol Genese, the current Coordinator for Surveillance and Epidemiological Response, will head the Clinical Section. Ms. Genese and her staff will concentrate on implementing the operational plans proposed in this cooperative agreement for bioterrorism preparedness, with an emphasis on health-care facilities and their integration with their LHDs, community and county bioterrorism task forces.

The Hospital Bioterrorism Preparedness Planning Committee (the Advisory Committee) was convened on March 5, 2002 to: review the results of the various needs assessment surveys pertaining to hospital and healthcare facilities; identify and prioritize approaches to addressing the needs identified through the various surveys; and, provide guidance and direction to the state in planning and implementation for bioterrorism response. The Advisory Committee will continue to perform all of the above activities throughout the life of the Cooperative Agreement and will meet at least quarterly during the implementation phase to monitor the progress of the implementation plan measured against established timelines, assess and address barriers to achieving the plans' goals, advise the NJDHSS on changing needs and priorities, and assume responsibilities as individuals or organizations to participate in the implementation process, as appropriate.

The Emergency Medical Services (EMS) system in New Jersey is a two-tiered system. Advanced Life Support is provided through hospital-based mobile intensive care units (MICU) and through the aero-medical program. Basic Life Support is provided by a large contingent of volunteer squads, as well as licensed municipal and private providers. Both tiers are coordinated in a disaster situation by the NJDHSS Office of Emergency Medical Services (OEMS), through the State Emergency Operations Center. The OEMS is directed by Ms. Susan Way who will work closely with Bioterrorism Unit staff, LINCS agencies, state and county OEMs and the NJHA to develop regional and statewide preparedness and response plans.

The implementation timeline covers a 24-month period.